



PsycHealth, Ltd.

MEDICAL RECORD DOCUMENTATION

Why is Documentation Important?

Medical record documentation is required to record pertinent facts, findings and observations about the patient's health history, including past and present illnesses, tests, treatments and outcomes. The medical record chronologically documents the care provided promoting quality care. The medical record should facilitate:

- the ability of the treating providers to evaluate and plan the patient's immediate treatment and to monitor health over time;
- communication and continuity of care among providers involved in the patient's care;
- appropriate utilization review and quality of care evaluations;
- accurate and timely claims review and payment;
- collection of data that may be useful for research and education.

A well documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided.

What do payers want and why?

Because payers have a contractual obligation to our enrollees, they require reasonable documentation that services are consistent with the insurance coverage. PsycHealth, Ltd. may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided;
- the services have been accurately reported.



PsycHealth, Ltd.

GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of services in all settings.

1. The medical record should be organized, complete and legible.
2. Each patient encounter should include:
 - Reason for the encounter and relevant history, findings of examination and prior diagnostic test results, if applicable;
 - Assessment, clinical impression or diagnosis;
 - Plan for care; and
 - Date and legible identity of the practitioner.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be clearly inferred.
4. Past and present illnesses and diagnoses should be easily accessible in the record.
5. Relevant health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The documentation should support the CPT and ICD-9 codes reported on the health insurance claim form or billing statement.

DOCUMENTATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES

There are seven components which define the levels of E/M services according to CPT descriptor guidelines. These components are:

- History;
- Examination;
- Medical decision making;
- Counseling;
- Coordination of care;
- Nature of presenting problem; and
- Time spent with patient



PsycHealth, Ltd.

The first three components (history, examination and medical decision making) are key components in establishing the level of E/M Services. In the case of visits which consist predominantly of counseling and coordination of care, time is the key or controlling factor to qualify for a particular level of E/M services.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on 4 types of history (Problem Focused, Expanded Problem Focused, Detailed and Comprehensive). Each type of history includes some or all of the following elements:

- Chief Complaint
- History of present illness
- Review of Systems
- Past, family and/or social history

B. DOCUMENTATION OF EXAMINATION

The levels of E/M services are based on 4 types of examination:

- Problem Focused – *a limited examination of the affected body area or organ system*
- Expanded Problem Focused - *a limited examination of the affected body area or organ system and any other symptomatic or related body area.*
- Detailed – *an extended examination of the affected body area(s) and/or system(s) and any other symptomatic or related body area*
- Comprehensive – *a general multi-system exam or complete exam of a single system and other symptomatic or related body area*

Elements of a Psychiatric Examination

- Description of speech including: rate, volume, articulation, coherence, and spontaneity with notation of abnormalities (eg, perseveration, paucity of language)
- Description of thought processes including: rate, content (eg, logical vs. illogical, tangential) abstract reasoning and computation
- Description of associations
- Description of abnormal psychotic features including: hallucinations, delusions, homicidal/suicidal ideations, obsessions)



PsycHealth, Ltd.

- Description of the patient's judgment (concerning everyday activities and social situations) and insight (concerning psychiatric condition)
- Complete Mental Status Examination including:
 - Orientation to time, place and person
 - Recent and remote memory
 - Attention span and concentration
 - Language
 - Fund of Knowledge (awareness of current events, past history, etc.)
 - Mood and affect

Content and Documentation Requirements

Level of Exam

Perform and Document:

Problem Focused

One to five elements

Expanded Problem Focused

At least 6 elements

Detailed

At least nine elements

Comprehensive

Perform all elements

C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

There are 4 types of medical decision making (straight forward, low complexity, moderate complexity and high complexity). The type of medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, tests and/or information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities associated with the patient presenting problems, the diagnostic procedures and/or possible management options.